



the children's center
REHABILITATION HOSPITAL

Medical Optimization Program Application for Admission

PATIENT INFORMATION				
Please print. Fill in all blanks.				
PATIENT - First Name		Middle Initial	Last Name	
Date of Birth		Gender	Social Security #	
Father's Name			Mother's Name	
REFERRING DOCTOR or FAMILY PHYSICIAN – Name			Ref. Dr.'s Phone # (with area code)	Ref. Dr.'s Fax # (with area code)
Referring Doctor's Address		City	State	Zip Code
CUSTODIAL PARENT/GUARDIAN – Name (if different from above)			Relationship to Patient	
Address		City	State	Zip Code
Employer		Home phone (with area code)	Work phone (with area code)	Cell phone (with area code)
NEXT OF KIN – Name			Relationship to Patient	
Address		City	State	Zip Code
Employer		Work phone (with area code)	Home phone (with area code)	Cell phone (with area code)
MEDICAID OR DDSD FUNDING				
Medicaid Number		Case Manager	Phone Number	
INSURANCE INFORMATION				
PRIMARY INSURANCE COMPANY – Name		Insured's Name		Insured's Date of Birth
Case Manager		Phone Number		
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address		City	State	Zip Code
SECONDARY INSURANCE COMPANY – Name		Insured's Name		Insured's Date of Birth
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address		City	State	Zip Code

Is your child adopted? Yes / No

If yes, please answer following questions to the best of your knowledge.

PREGNANCY

Pregnancy with this patient was: Normal with Complications (explain)

FAMILY HISTORY

Any medical conditions that are in the family? (asthma, ADHD, heart disease, seizures,)

Who lives in the home with the patient currently?

Who is the primary caregiver for your child?

MEDICAL HISTORY:

Current diagnosis/new problems or concerns: _____

Current medications-please bring you child's current medications at the time of admission:

Medication	Dose	Route	Time given/frequency
(ex:) Keppra	5 mg	Gtube	8 am and 8 pm

Home Pharmacy: Name _____ **Phone Number** _____

Respiratory medications-please bring your child's current respiratory medications at the time of admission.

Medication	Dose	Route	Time given/frequency:
(ex:) Albuterol	Two puffs	By mouth	As needed

Airway clearance:

Treatment	Frequency	Other
(ex) Vest treatment	Twice a day	15 minutes

Major illnesses and hospitalizations: _____

Allergies: _____

Surgical procedures and dates: (orthopedic, ENT, etc.) _____

Current diet: _____ Formula: _____ Volume: _____

Times: _____ Additional water: _____ Modifiers (Benefiber, etc.): _____

Current height: _____ Weight: _____

Are immunizations up to date? Flu shot? _____

EDUCATION HISTORY – ATTACH COPY OF CURRENT IEP (Individual Education Plan)

Is your child currently attending school? Yes No

If yes, where? _____

Has your child been evaluated for or placed in any special classes (i.e., lab tutoring, remedial instructions, etc.)? Yes No

If yes, what services does he/she receive and how often? _____

Has your child had a Visual Screening? Yes No

Results: _____

Has your child had a Hearing Screening? Yes No

Results: _____

REHABILITATION HISTORY- ATTACH A COPY OF CURRENT OUTPATIENT THERAPIES GOALS, EVALUATIONS AND PLAN OF CARE

Has your child previously **received therapy**? Yes No

If yes, please provide the following information, beginning with the most recent:

Dates Attended	Location of Treatment	Therapy Type PT, OT, ST, MT Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST) Music Therapy (MT)	Therapist and Telephone #	Frequency of Treatment
to				
to				
to				
to				
to				

Is your child currently using any adaptive equipment?

Yes No If yes, check all that apply

- | | |
|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Stander | <input type="checkbox"/> Positioning equipment |
| <input type="checkbox"/> Splints/Braces | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Switches | <input type="checkbox"/> Hearing aide |
| <input type="checkbox"/> Communication device | <input type="checkbox"/> Speaking valve |
| <input type="checkbox"/> Feeding equipment | <input type="checkbox"/> Bathing equipment |

Other, (specialty bed, etc)

Does your child have special transportation needs? (medical transport, medical car seat, etc.) _____

What are your child's current functional abilities? _____

What are your child's current functional limitations? _____

Please mark all of the following that your child is able to perform at this time:

- | | |
|--------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> head control | <input type="checkbox"/> standing |
| <input type="checkbox"/> rolling | <input type="checkbox"/> cruising |
| <input type="checkbox"/> sitting with support | <input type="checkbox"/> walking with assistance |
| <input type="checkbox"/> sitting without support | <input type="checkbox"/> walking without assistance |
| <input type="checkbox"/> crawling | <input type="checkbox"/> eating by mouth |

Please describe your child's typical day/schedule:

Which of the following services do you feel would most benefit your child during admission? Any specific goals/concerns for each therapy?

- Physical therapy _____
- Occupational therapy _____
- Speech-language pathology _____
- Music therapy _____
- Recreation therapy _____

SOCIAL SERVICES:

Are there any services, equipment or information that would make caring for your child at home easier?

Please list previous stays your child has had out of your home besides The Children's Center (i.e. evaluation, etc.).

Facility: _____ Dates: _____

Reason: _____

Facility: _____ Dates: _____

Reason: _____

Please return completed packet to The Children's Center Rehab Hospital 10-14 days prior to admission.

The Children's Center Rehab Hospital

Attn: Admissions

Donald W. Reynold's Complex

6800 NW 39th Expressway

Bethany, OK 73008 or

Referrals@tccokc.org or

Fax: 1-844-785-7681

Thank you for allowing us to care for your child.